

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11746  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

No. 51

1. PLACE OF DEATH: COUNTY <u>Calvert</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Donnington</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>Calvert</u> CITY (If outside corporate limits write RURAL and give nearest town) <u>Donnington</u> OR TOWN STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED: (Type or Print) (First) <u>Frank</u> (Middle) <u>L</u> (Last) <u>Brown</u>				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>16</u> (Year) <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>June 26 '86</u>	
9. AGE last birthday: <u>69</u> yrs.				10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Common laborer Baltimore</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>MD</u>		11. BIRTHPLACE (State or foreign country): <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>				13. FATHER'S NAME: <u>McHenry Brown</u>			
14. MOTHER'S MAIDEN NAME: <u>Fannie Rawling</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY No.: <u>21-28-4563</u>				17. INFORMANT & ADDRESS: <u>Mrs Edith Brown</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>420.1</u> Immediate cause (a) <u>Crown disease</u> DUE TO Antecedent cause(s) (b) <u>  </u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Found dead in bed</u>							
19a. DATE OF OPERATION: <u>  </u>				19b. MAJOR FINDING OF OPERATION: <u>  </u>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				21. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY) <u>Donnington Calvert MD</u>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. CITY OR TOWN (County) (State) <u>Donnington Calvert MD</u>			
21c. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>  </u> M.				21d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
21e. HOW DID INJURY OCCUR? <u>  </u>							
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> SIGNATURE <u>H. W. Ward</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12/16/55</u> M. D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <u>  </u>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried</u>		DATE THEREOF: <u>Dec. 18, 1955</u>		NAME OF CEMETERY OR CREMATORY: <u>Wesley Cemetery</u>		LOCATION (City, town, or county) (State): <u>Prince Frederick, Md</u>	
DATE REC'D BY LOCAL REG: <u>12/17/55</u>		REGISTRAR'S SIGNATURE: <u>H. W. Ward</u>		24. FUNERAL DIRECTOR: <u>A. B. Hackness &amp; Son - Mutual, Ind.</u>			
ADDRESS: <u>  </u>							

BUREAU V. S.

DEC 20 1965

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11747

11747 **CERTIFICATE OF DEATH**

Reg. Dist. No. 51

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Cabaret</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Cabaret</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Huntingtown</i>		<i>Life</i>		TOWN <i>Huntingtown</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<i>ay. Kent Bowie</i>				<i>Dec. 22, 1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>M</i>	<i>W</i>	<i>D</i>	<i>Feb. 22, 1877</i>	<i>78</i> yrs.	Months <i>10</i>	Days <i>0</i>	Hours <i>0</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Farm Owner</i>		<i>Farming</i>		<i>Mt. Zion, A.A. Co. Md.</i>		<i>U.S.A.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Edmund L. Bowie</i>				<i>Violetta Belt</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>None</i>		<i>no</i>		<i>E. Lansdale Bowie, Lithuanian</i>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
163X IMMEDIATE CAUSE (A) <i>Carcinoma of Lung.</i>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12/2</i> , 19 <i>53</i> , to <i>12/22</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>12/22</i> , 19 <i>55</i> , and that death occurred at <i>12/22</i> , 19 <i>55</i> , M, from the causes and on the date stated above.							
SIGNATURE <i>E. D. Weems</i>				ADDRESS (Street, city, town, state) <i>Huntingtown Md</i>		DATE SIGNED <i>12/23/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Dec. 24, 1955</i>		NAME OF CEMETERY OR CREMATORY <i>All Saints' Cem</i>		LOCATION (City, town, or county) (State) <i>Huntingtown, Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>H. W. Ward</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Harkness - Mutual, Md.</i>		ADDRESS	
DATE <i>12-24-55</i>							

11341

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

# DEATH CERTIFICATE

DATE OF DEATH

1. NAME OF DECEASED

2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH  
6. OCCUPATION  
7. MARITAL STATUS  
8. COLOR  
9. RELIGION  
10. EDUCATION  
11. SERVICE  
12. PLACE OF DEATH  
13. DATE OF DEATH  
14. TIME OF DEATH  
15. CAUSE OF DEATH  
16. MANNER OF DEATH  
17. SIGNATURE OF PHYSICIAN  
18. SIGNATURE OF WITNESSES  
19. SIGNATURE OF REGISTRAR  
20. SIGNATURE OF CLERK

3. PLACE OF DEATH

4. DATE OF DEATH

5. TIME OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF WITNESSES

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF CLERK

12. SIGNATURE OF CLERK

13. SIGNATURE OF CLERK

14. SIGNATURE OF CLERK

15. SIGNATURE OF CLERK

16. SIGNATURE OF CLERK

17. SIGNATURE OF CLERK

18. SIGNATURE OF CLERK

19. SIGNATURE OF CLERK

20. SIGNATURE OF CLERK

21. SIGNATURE OF CLERK

22. SIGNATURE OF CLERK

23. SIGNATURE OF CLERK

24. SIGNATURE OF CLERK

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26. SIGNATURE OF CLERK

27. SIGNATURE OF CLERK

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37. SIGNATURE OF CLERK

38. SIGNATURE OF CLERK

39. SIGNATURE OF CLERK

40. SIGNATURE OF CLERK

BUREAU V. S.

DEC 29 1955

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BALTIMORE  
DEC 29 1955  
MAY 1956

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11748

11748 **CERTIFICATE OF DEATH**

Reg. Dist. No. 51

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Calvert</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Calvert</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Prince Federal</i>		<i>14 hrs</i>		TOWN <i>Sunderland</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Calvert Co H</i>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Virginia</i> (First) (Middle) (Last) <i>Virginia</i>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>12 24 1955</i>			
<b>5. SEX</b> <i>F</i>	<b>6. COLOR OR RACE</b> <i>C</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>D</i>	<b>8. DATE OF BIRTH</b> <i>July 30, 1957</i>	<b>9. AGE last birthday</b> <i>4</i> yrs.	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
					Months	Days	Hours
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Teacher</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Md</i>		<b>12. CITY OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <i>Wm Virginia</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Helen Creek</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <i>Mother</i>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>916.0 IMMEDIATE CAUSE (A)</b> <i>Shock due to first, second</i>							
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <i>third degree burn 7 days</i>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <i>burn injures to breasts &amp; stomach</i>						<i>14 hrs</i>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <i>Burn was not a fire by old child</i>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b> <i>Home</i>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State) <i>Prince Frederick Calvert Md</i>			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) <i>12/23/55 7 P.M.</i>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> <i>Old child at fireplace</i>		<i>04</i>	
<b>22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>H. W. Ward M.D.</i>				<b>ADDRESS</b> (Street, city, town, state) <i>Way of the Cross Sunderland</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b> <i>12-24-55</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>Way of the Cross</i>		<b>LOCATION</b> (City, town, or county) (State) <i>Sunderland Md</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>H. W. Ward</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>P. E. Sawell</i>		<b>ADDRESS</b> <i>Prince Frederick Md</i>	
<b>DATE</b> <i>12-24-55</i>							

**BUREAU V. S.**

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DEC 29 1955



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INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11749

11749

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>CALVERT</u>		STATE <u>MARYLAND</u>		COUNTY <u>CALVERT</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>PRINCE FREDERICK</u>		<u>1 HOUR</u>		<u>MUTUAL</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
<u>CALVERT COUNTY HOSPITAL</u>				<u>/</u>			
<b>3. NAME OF DECEASED</b>				<b>4. DATE OF DEATH</b>			
(Type or Print) <u>WARREN GANTT</u>				(Month) (Day) (Year)			
				<u>12</u> <u>11</u> <u>55</u>			
<b>5. SEX</b>		<b>6. COLOR OR RACE</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)</b>		<b>8. DATE OF BIRTH</b>	
<u>MALE</u>		<u>COLORED</u>		<u>MARRIED</u>		<u>10-22-1892</u>	
						<b>9. AGE last birthday</b>	
						<u>63</u> yrs.	
						IF UNDER 1 YEAR	
						Months Days	
						IF UNDER 24 HRS.	
						Hours Min.	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b>	
						<u>Calvert County, Maryland</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b>							
<u>U.S.A.</u>							
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>JOHN W. GANTT</u>				<u>CAROLINE WHITE</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b>				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>	
						<u>MRS. CHARLOTTE GANTT, MUTUAL, MD.</u>	
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<u>3 hours</u>	
<u>420.1</u> IMMEDIATE CAUSE (A) <u>CORONARY THROMBOSIS</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b>	
						YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
<b>22. I hereby certify that I attended the deceased from <u>12/11/55</u>, to <u>12/11/55</u>, that I last saw the deceased alive on <u>12/11/55</u>, and that death occurred at <u>3:40</u> M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>DATE SIGNED</b>			
<u>P. E. Sewell</u>				<u>12/11/55</u>			
<b>23. (BURIAL, CREMATION, REMOVAL) (SPECIFY)</b>				<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>	
<u>BURIAL</u>				<u>12-14-55</u>		<u>Brooks Chapel</u>	
<b>24. REC'D BY REGISTRAR</b>				<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>	
<u>DATE 12-12-55</u>				<u>Dr. H. W. Ward</u>		<u>P. E. Sewell, Prince Fred, Md.</u>	

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DEC 14 1955  
BUREAU V. S.

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1955

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF DISTRICT ATTORNEY

18. SIGNATURE OF STATE ATTORNEY

19. SIGNATURE OF ATTORNEY GENERAL

20. SIGNATURE OF SECRETARY OF STATE

21. SIGNATURE OF COMMISSIONER OF REVENUE

22. SIGNATURE OF COMMISSIONER OF LABOR

23. SIGNATURE OF COMMISSIONER OF EDUCATION

24. SIGNATURE OF COMMISSIONER OF AGRICULTURE

25. SIGNATURE OF COMMISSIONER OF FISHERIES

26. SIGNATURE OF COMMISSIONER OF NATURAL RESOURCES

27. SIGNATURE OF COMMISSIONER OF PUBLIC SAFETY

28. SIGNATURE OF COMMISSIONER OF TRANSPORTATION

29. SIGNATURE OF COMMISSIONER OF CONSUMER AFFAIRS

30. SIGNATURE OF COMMISSIONER OF ECONOMIC DEVELOPMENT

31. SIGNATURE OF COMMISSIONER OF ENVIRONMENTAL AFFAIRS

32. SIGNATURE OF COMMISSIONER OF GENERAL SERVICES

33. SIGNATURE OF COMMISSIONER OF HUMAN RESOURCES

34. SIGNATURE OF COMMISSIONER OF INFORMATION TECHNOLOGY

35. SIGNATURE OF COMMISSIONER OF LEGAL SERVICES

36. SIGNATURE OF COMMISSIONER OF PLANNING

37. SIGNATURE OF COMMISSIONER OF PUBLIC WORKS

38. SIGNATURE OF COMMISSIONER OF RETIREMENT

39. SIGNATURE OF COMMISSIONER OF SOCIAL SERVICES

40. SIGNATURE OF COMMISSIONER OF STATE POLICE

41. SIGNATURE OF COMMISSIONER OF STATE TROOP

42. SIGNATURE OF COMMISSIONER OF STATE FIRE MARSHAL

43. SIGNATURE OF COMMISSIONER OF STATE ARCHIVES

44. SIGNATURE OF COMMISSIONER OF STATE LIBRARY

45. SIGNATURE OF COMMISSIONER OF STATE MUSEUM



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11750  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11750  
 Reg. Dist. No. 51

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Calvert</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Calvert</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <b>Prince Frederick</b>		<i>days</i>		TOWN <b>Prince Frederick</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<b>GEORGE BROOK DORSEY GRAY</b>				<b>12/27 1955</b>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday: yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<b>Male</b>	<b>White</b>	<b>Married</b>		<b>60</b>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life; even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>Admission Clerk Assistant</i>		<i>Biological Lab</i>		<i>Calvert Co., Md</i>		<i>U.S.A.</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>John B. Gray</i>				<i>Kathie L. Dorsey</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<i>3 No</i>		<i>220-16-8130</i>		<i>Yvonne Gray - Prince Frederick, Md</i>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a)..... <b>Gunshot wound of brain</b> DUE TO Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c).....							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
<i>2</i>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town) (County) (State)			
		<i>home</i>		<b>Calvert Md.</b>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>12/27/55 3:30 PM.</b>				<b>Shot self in head</b>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>R. F. Fisher</i>		<i>Dec. 30, 1955</i>		<i>St. Paul's Cemetery</i>		<i>Prince Frederick, Md</i>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<i>Burial</i>		<i>12-29-55</i>		<i>H. H. Hard</i>		<i>B. A. Warkness &amp; Son - Mutual, Md.</i>	

BUREAU V. S.

JAN 2 1956

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11751

11751

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 51

1. PLACE OF DEATH COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Winton</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Winton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (Type or Print) <u>Engene Orlando Johnson</u>		4. DATE OF DEATH <u>12 22 1935</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>Jan 23, 1882</u>
9. AGE last birthday: <u>53</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Benj. Johnson</u>		14. MOTHER'S MAIDEN NAME: <u>Julia Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: <u>Clifton Johnson, Winton, MD</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Fractured skull &amp; broken neck</u>			
Antecedent cause(s) (b) <u>Force ran away</u>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>Home</u>	21c. (City or town) (County) (State): <u>Winton Calvert MD</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE: <u>H. W. Ward</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: <u>12/22/35</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM.	
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF: <u>12-26-35</u>	NAME OF CEMETERY OR CREMATORY: <u>Island Creek</u>	LOCATION (City, town, or county) (State): <u>Winton MD</u>
DATE REC'D BY LOCAL REG. <u>12-23-35</u>	REGISTRAR'S SIGNATURE: <u>H. W. Ward</u>	24. FUNERAL DIRECTOR: <u>P. H. Sewell</u> ADDRESS: <u>Prince Frederick</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 29 1955

BUREAU V. S.

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11752

## 11752 CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Washington, D.C.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Prince Frederick</u>		<u>22 hrs. 40 min.</u>		TOWN <u>Washington D.C.</u>		<u>47X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert Co. Hospital</u>				STREET ADDRESS (If rural give location) <u>1364 Randolph St. N.W.</u>			
3. NAME OF DECEASED (Type or Print) <u>William</u> (First) <u>B.</u> (Middle) <u>hanigan</u> (Last)				4. DATE OF DEATH <u>12-25</u> (Month) <u>25</u> (Day) <u>1955</u> (Year)			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>June 21-1892</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William F. Hanigan</u>				14. MOTHER'S MARDEN NAME <u>Margaret Jacques</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-sclerosis (Hypertension)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 25, 1955</u> , to <u>Dec 25, 1955</u> , that I last saw the deceased alive on <u>Dec 25, 1955</u> , and that death occurred at <u>3:45</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>Robert B. Premplsey</u>				ADDRESS (Street, city, town, state) <u>St Leonard</u>		DATE SIGNED <u>Dec 25/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/29/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Leonard Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
24. REC'D BY REGISTRAR <u>12-28-55</u>		REGISTRAR'S SIGNATURE <u>H. W. Ward</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert B. Premplsey</u>		ADDRESS <u>Bethesda</u>	





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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11753

## 11753 CERTIFICATE OF DEATH

Reg. Dist. No. 52

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Calvert County</u>		STATE <u>Maryland</u>		COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>North Beach</u>		<u>4 hrs.</u>		TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert County Hospital</u>				STREET ADDRESS (If rural give location) <u>Prince Frederick, Maryland</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) (Middle) (Last) <u>William Oscar Marshall</u>				<u>Dec. 20, 1955</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<u>Male</u>	<u>White</u>	<u>Wid.</u>	<u>July 19, 1875</u>	<u>80</u> yrs.	Months Days	Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Manager</u>		<u>Restaurant</u>		<u>Maryland</u>		<u>U.S.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Samuel Wm. Marshall</u>				<u>Evans</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>unk.</u>				<u>Miss Maria Marshall - North Beach, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<u>422.1</u> IMMEDIATE CAUSE (A) <u>acute Pulmonary Edema</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>arterio sclerotic C.V. Disease</u>				<u>8 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, of INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Page J. H.</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Prince Frederick</u>			
<b>DATE</b> <u>Dec 20, 1955</u>				<b>DATE SIGNED</b> <u>12/20/55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION</b> (City, town, or county) (State)	
<u>Cedar Hill Cem.</u>		<u>12/23/55</u>		<u>Cedar Hill Cemetery</u>		<u>Suitland Md</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
<u>DEC 20 1955</u>		<u>Chas B. Cox</u>		<u>J. H. Harrison Co.</u>			
<b>DATE</b>				<b>ADDRESS</b> <u>300 4th St. NE Lee Funeral Home</u>			

BUREAU V. 11

DEC 28 1955

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11754

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11754  
Reg. Dist.

No. 51

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Adelina Md.</u>			
TOWN <u>Island Creek</u>				STREET ADDRESS (If rural, give location) <u>7</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED: (Type or Print)		(First) <u>John</u> (Middle) <u>Thomas</u> (Last) <u>Willet</u>		4. DATE OF DEATH		(Month) <u>12</u> (Day) <u>25</u> (Year) <u>1955</u>	
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>Jan 21</u>	9. AGE last birthday: <u>18</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>farm labor</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>P</u>				14. MOTHER'S MAIDEN NAME: <u>Florence Willett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.: <u>217-32-3002</u>		17. INFORMANT & ADDRESS: <u>Florence Willett, Adelina Md</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Gunshot wound (shotgun) of Left Chest</u> Antecedent cause(s) (b) <u>Massive Thoracic Hemorrhage</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Skull Fracture</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>2</u>		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12-25-55</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>William Updell</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12-26-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <u>P.F. Sewell Prince Frederick Md</u>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF <u>12-29-55</u>		NAME OF CEMETERY OR CREMATORY <u>Carrville</u>		LOCATION (City, town, or county) (State) <u>Barstow Md</u>	
DATE REC'D BY LOCAL REG. <u>12-29-55</u>		REGISTRAR'S SIGNATURE <u>R.W. Ward</u>		24. FUNERAL DIRECTOR <u>P.F. Sewell Prince Frederick Md</u>		ADDRESS	

BUREAU V. S.

JAN 2 1966

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